

REQUEST FOR THE RELEASE OF HEALTH INFORMATION

Please indicate the following information regarding the person whose health information is to be released.

Name _____	ID# _____	DOB ____/____/____ (DD/MM/YY)	
Address _____	City _____	State _____	Zip _____

If a request is being made to send this information to a third party please complete the following information.

Third Party Name _____	Relationship to Member _____
Third Party Address _____	City _____ State _____ Zip _____

Authorization and/or Personal Representative records need to be on file in order to send info to third party.

I, the undersigned, hereby request that MVP Health Plan, Inc., MVP Select Care, Inc., MVP Health Insurance Company or MVP Health Services Corp. (collectively "MVP Healthcare") disclose to me the health information identified below:

- ____ 1. Medical claim information for a specific condition (State name of condition here) _____
- ____ 2. Medical claim information for a specific date (Specify date here) _____
- ____ 3. Medical claim information for a specific period of time: From _____ to _____

- ____ 4. Pharmacy claim information for a specific condition (State name of condition here) _____
- ____ 5. Pharmacy claim information for a specific date (Specify date here) _____
- ____ 6. Pharmacy claim information for a specific period of time: From _____ to _____

- ____ 7. Dental claim information for a specific condition (State name of condition here) _____
- ____ 8. Dental claim information for a specific date (Specify date here) _____
- ____ 9. Dental claim information for a specific period of time: From _____ to _____

- ____ 10. Utilization Management information for a specific condition (State name of condition here) _____
- ____ 11. Appeals information for a specific case (Specify case# or date of service here) _____
- ____ 12. Eligibility/Enrollment information for a specific period of time: From _____ to _____

Other _____

The following items must be initialed to be included in the disclosure of health information:

- ____ HIV/AIDS related information and/or records
- ____ Pregnancy/Family Planning related information
- ____ Mental health information and/or records
- ____ Drug/alcohol diagnosis and treatment information

Signature of Member

Date

Signature of Requester

Relationship to Member

(Please provide legal documentation if requestor is NOT the member or is NOT the parent of a minor member)